

EXHIBIT 2



Beth Reisch, Paralegal
Paralegal
Direct: (615) 252-3553
Fax: (615) 248-3015
breisch@babco.com

July 18, 2013

Matthew Cline
Gideon, Cooper and Essary
Suite 1100, 315 Deaderick Street
Nashville, Tennessee 37238

Re: Requests for St. Thomas Hospital West Medical Records of Meningitis Claimants

Dear Mr. Cline:

Pursuant to your July 12, 2013 request for the St. Thomas Hospital West medical and billing records of 75 claimants, please find attached a listing of 30/75 claimants whose HIPAA releases are deficient. Also enclosed are the releases for each of the 30 claimants.

Please return them to their respective attorneys for completion and we will provide you with the records you are requesting.

Sincerely,

A handwritten signature in cursive script that reads 'Beth Reisch'.

Beth Reisch, Paralegal

br
Attachment and enclosures as stated
Cc: Amy D. Hampton
Lela Hollabaugh

RECEIVED
JUL 19 2013

7/3172157.1

DEFICIENT RELEASES

	CLAIMANT	DEFICIENT
1.	ALEXANDER, JOHN	No provider designated
2.	BESAW, TRAVIS	No provider or recipient designated
3.	BRATCHER, BEN	No provider or recipient designated. Requests psychotherapy records only.
4.	BRYANT, MARGARET	Expired release submitted without certificate of death; type of records not designated
5.	CAMPBELL, BARBARA	No provider or recipient designated. Requests psychotherapy records only.
6.	CARROLL, THERESA	No provider or recipient designated
7.	CHAMBERS, KATHY	Incorrect provider & recipient
8.	COLEMAN, BILLY JOE	No provider or recipient designated
9.	EVANS, DANNY	No provider or recipient designated
10.	FERGUSON, ROSEMARY	Undated release
11.	GLATMAN, ELLEN	Undated release; no recipient designated
12.	JORDAN, DORRIS	Undated release; no recipient designated
13.	KINSEY, JOHN	Undated release; no recipient designated
14.	LANKFORD, CHARLES	Undated release; no recipient designated
15.	LOVELACE, EDDIE	Release submitted without out certificate of death
16.	MARTIN, MARY NEAL	Release submitted without out certificate of death
17.	MCKINNEY, JOYCE	No provider designated
18.	MILLER, MELANIE	No provider or recipient designated. Requests psychotherapy records only.
19.	NASEEF, DOROTHY	No provider or recipient designated
20.	PIERCE, KEN	No provider or recipient designated
21.	PRUITT, ELIZABETH	Release submitted without out certificate of death
22.	RAGLAND, J.W.	Release submitted without out certificate of death
23.	RYBINSKI, THOMAS	Release submitted without out certificate of death
24.	SAWYERS, JOHN	No provider designated
25.	STINSON, MELAINE	No provider or recipient designated
26.	TAYLOR, BARBARA	No provider designated
27.	TAYLOR, BLAKE	No provider or recipient designated. Requests psychotherapy records only.
28.	TURNER, RONDAL	No provider or recipient designated
29.	WILKINSON, KRISSY	No provider or recipient designated
30.	WILLIAMS, EARLINE	Release submitted without out certificate of death

AUTHORIZATION FOR PRODUCTION OF MEDICAL DOCUMENTATION

Pursuant to TENNESSEE CODE ANNOTATED §29-26-122(a)(2)(E), I, John L. Alexander, Sr., have executed this HIPAA-compliant medical authorization that authorizes the Saint Thomas Outpatient Neurosurgical Center, LLC, and/or the designated legal representative for Saint Thomas Outpatient Neurosurgical Center, LLC, to obtain complete medical records regarding myself, John L. Alexander, Sr., Social Security Number +9620, and date of birth (/1953.

The medical documentation which is authorized to be copied and produced to Saint Thomas Outpatient Neurosurgical Center, LLC, and/or the designated legal representative for Saint Thomas Outpatient Neurosurgical Center, LLC, would include, but not be limited to, medical records, medical reports, medical charts, X-ray reports or films, diagnostic studies, psychiatric records, psychological records, pharmacy or prescription medication records, pathology reports or slides, medical billing statements, and/or other documents, writings or tangible things related to the medical care and treatment of John L. Alexander, Sr.. The medical information that is authorized to be produced includes, but is not limited to, protected health information as defined at 45 C.F.R. 164.500, *et seq.*, (The HIPAA Privacy Rule).

I, John L. Alexander, Sr., understand that the information in the health records may include information which is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.


I, John L. Alexander, Sr., understand that I have the right to revoke this authorization at any time. I, John L. Alexander, Sr., understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department and/or employment human resources or personnel department. I, John L. Alexander, Sr., understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, or event or condition: June 28, 2020.

I, John L. Alexander, Sr., understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization. I, John L. Alexander, Sr., understand that I may inspect or copy the information to be used or disclosed, as provided by CFR 164.524. I, John L. Alexander, Sr., understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I, John L. Alexander, Sr., understand that the medical documentation and health information is being disclosed due to my claims for the severe injuries which I allege were caused when I was injected with contaminated drug products while I was under the care and treatment of Saint Thomas Outpatient Neurosurgical Center, LLC. The contaminated drug products were obtained by Saint Thomas Outpatient Neurosurgical Center, LLC from New England Compounding Pharmacy, LLC.

This health information may be disclosed to and may be used by the following organization:

Saint Thomas Outpatient Neurosurgical Center, LLC, and/or the designated
legal representative for Saint Thomas Outpatient Neurosurgical Center, LLC
4230 Harding Road, Suite 901
Nashville, TN 37205
Telephone # (615) 341-3425


John L. Alexander, Sr.

Date: 6/28/13

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <u>Travis Besaw</u>	Birth Date: <u>7/82</u>	Social Security No. (optional): <u>9369</u>	
Provider's/Health Plan's Name:	Recipient's Name:		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. YJB (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>Travis Besaw</u>	Date: <u>5/17/13</u>
Print Name of Patient/Plan Member's Representative: <u>Robert Young</u>	Relationship to Patient/Plan Member: <u>Attorney</u>

Revised 3/2003

Section A: This section must be completed for all Authorizations:

Patient/Plan Member Name: Ben Batchel	Birth Date: 1/78	Social Security No. (optional): 9540	
Provider's/Health Plan's Name:	Recipient's Name:		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **April 1, 2014** Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☒ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. **BGB** (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Benjamin G. Batchel	Date: 5-20-13
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

AUTHORIZATION FOR USE OR DISCLOSURE OF

PROTECTED HEALTH INFORMATION

Patient Name: Margaret Rhea BryantSocial Security Number: -7413Date of Birth: , 1938Phone Number: 931.668.4722

1. I authorize Saint Thomas Health Services, Saint Thomas Outpatient Neurosurgical Center, LLC, St. Thomas Hospital, St. Thomas Hospitalist Group, St. Thomas Neurology Group, PLC to disclose my health information to:

Galligan & Newman, 309 W. Main Street, McMinnville, TN 37110, Christina S. Sadlow, M.D., Damon M. Abaray, M.D., E. Berry Holt, III, Gregory B. Lanford, M.D., Heritage Medical Associates, P.C., Howell Allen Clinic, John R. Voigt, Esq., Joseph R. Zenisek, M.D., Steven A. Embry, M.D., Subir Prasad, M.D., Vanderbilt University Medical Center

The purpose(s) for the use or disclose is as follows: Litigation.

2. The type and amount of information to be used or disclosed is as follows:

Health information covering treatment from July 1, 2012 to September 18, 2012.

☐ Abstract (includes H&P, Progress Notes, Procedure Notes, Procedure Reports, etc.)

☐ Summary

☐ Copy of Medical Records only

☐ Discharge Summary (DS)

☐ Copy of Complete Records (Medical & Financial)

☐ Operative/Procedure Report(OP)

☐ History and Physical (H&P)

☐ Pathology Report

☐ Consultation

☐ Laboratory Report

Other:

3. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

4. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.

5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. The doctor or hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize the above named provider to disclose my health information, the health information may be subject to redisclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have any questions about disclosure of my health information I can contact the provider listed above.

Bertan W. Bryant
Signature of Patient or Legal Representative

Oct. 5, 2012
Date

If signed by Legal Representative, Relationship to Patient

Section A: This section must be completed for all Authorizations.					
Patient/Plan Member Name: <u>Barbara Campbell</u>		Birth Date: <u>1/54</u>		Social Security No. (optional): <u>3280</u>	
Provider's/Health Plan's Name:		Recipient's Name:			
Provider's/Health Plan's Address:		Address 1:			
		Address 2:			
		City:		State:	Zip:
This authorization will expire on the following (Fill in the Date or the Event but not both.) Date: <u>April 1, 2014</u> Event:					
Purpose of disclosure: <u>COMPLIANCE WITH T.C.A. § 29-26-121</u>					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input checked="" type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. <u>BC</u> (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it.					
Section B:					
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>Barbara Campbell</u>				Date: <u>5/19/13</u>	
Print Name of Patient/Plan Member's Representative: <u>Barbara Campbell</u>				Relationship to Patient/Plan Member: <u>Attorney</u>	

Revised 3/2003

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <i>Theresa Carroll</i>	Birth Date: <i>4/9</i>	Social Security No. (optional): <i>-9568</i>	
Provider's/Health Plan's Name:	Recipient's Name:		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
 Date: *April 1, 2014* Event:

Purpose of disclosure: *COMPLIANCE WITH T.C.A. § 29-26-121*

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *TC* (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Theresa Carroll</i>	Date: <i>5/19/13</i>
Print Name of Patient/Plan Member's Representative: <i>Theresa Ann Carroll Robert Young</i>	Relationship to Patient/Plan Member: <i>Attorney</i>

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Kathy J. Chambers

Birth Date: 35/36/51

Social Security No.: 415-88-9081

Kathy Chambers

- 5'

- 9081

Persons or Organizations Authorized to Disclose the Information:

Persons or Organizations Authorized to Receive the Information:

Howell Allen Clinic a Professional Corporation

Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-12

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *RI* (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

*Kathy Chambers*2013
3-22-2013

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Kathy J. Chambers *Kathy Chambers*

Self

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations:					
Patient/Plan Member Name: <i>Billy Joe Coleman</i>		Birth Date: <i>159</i>		Social Security No. (optional): <i>3273</i>	
Provider's/Health Plan's Name:		Recipient's Name:			
Provider's/Health Plan's Address:		Address 1:			
		Address 2:			
		City:	State:	Zip:	
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: <i>April 1, 2014</i> Event:					
Purpose of disclosure: <i>COMPLIANCE WITH T.C.A. § 29-26-121</i>					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input checked="" type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
<input checked="" type="checkbox"/> I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. <i>BJC</i> (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it.					
Section B:					
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signature					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Billy Joe Coleman</i>				Date: <i>5/20/13</i>	
Print Name of Patient/Plan Member's Representative: <i>Robert Young</i>				Relationship to Patient/Plan Member: <i>Attorney</i>	

Revised 3/2003

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Danny Evans	Birth Date: 1/64	Social Security No. (optional): -1823	
Provider's/Health Plan's Name:	Recipient's Name:		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **April 1, 2014** Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. **DJE** (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Danny Evans	Date: 5/22/13
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)					
Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: Rosemary C. Ferguson		Birth Date: 1956		Social Security No. (optional):	
Provider's/Health Plan's Name: St. Thomas Hospital		Recipient's Name:			
Provider's/Health Plan's Address: 4220 Harding Road Nashville, TN 37205		Address 1:			
		Address 2:			
		City:	State:	Zip:	
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: April 1, 2014 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input checked="" type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it.					
Section B:					
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Rosemary C. Ferguson				Date:	
Print Name of Patient/Plan Member's Representative: Robert Young				Relationship to Patient/Plan Member: Attorney	

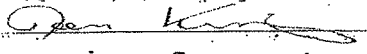
Revised 3/2003

Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: Ellen Glatman		Birth Date: 1960		Social Security No. (optional):	
Provider's/Health Plan's Name: St. Thomas Hospital		Recipient's Name:			
Provider's/Health Plan's Address: 4220 Harding Road Nashville, TN 37205		Address 1:			
		Address 2:			
		City:		State:	Zip:
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: April 1, 2014 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input checked="" type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it.					
Section B:					
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:				Date:	
Print Name of Patient/Plan Member's Representative: Robert Young				Relationship to Patient/Plan Member: Attorney	

Revised 3/2003

Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: Dorris Jordan		Birth Date: /1957		Social Security No. (optional):	
Provider's/Health Plan's Name: St. Thomas Hospital		Recipient's Name:			
Provider's/Health Plan's Address: 4220 Harding Road Nashville, TN 37205		Address 1:			
		Address 2:			
		City:	State:	Zip:	
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: April 1, 2014 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input checked="" type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it.					
Section B:					
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Dorris Jordan</i>				Date:	
Print Name of Patient/Plan Member's Representative: <i>Robert Young</i>				Relationship to Patient/Plan Member: <i>Attorney</i>	

Revised 3/2003

Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: John Kinsey		Birth Date: /1962		Social Security No. (optional):	
Provider's/Health Plan's Name: St. Thomas Hospital		Recipient's Name:			
Provider's/Health Plan's Address: 4220 Harding Road Nashville, TN 37205		Address 1:			
		Address 2:			
		City:	State:	Zip:	
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: April 1, 2014 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input checked="" type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it.					
Section B:					
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: 				Date:	
Print Name of Patient/Plan Member's Representative: Robert Young				Relationship to Patient/Plan Member: Attorney	

Revised 3/2003

Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: Charles Lankford		Birth Date: 1/1937		Social Security No. (optional):	
Provider's/Health Plan's Name: St. Thomas Hospital		Recipient's Name:			
Provider's/Health Plan's Address: 4220 Harding Road Nashville, TN 37205		Address 1:			
		Address 2:			
		City:		State:	Zip:
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: April 1, 2014 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input checked="" type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it.					
Section B:					
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Charles Lankford</i>				Date:	
Print Name of Patient/Plan Member's Representative: Robert Young				Relationship to Patient/Plan Member: Attorney	

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: Eddie C. Lovelace		Birth Date: 9/34		Social Security No.: 1-4889	
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic		Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC			
This authorization will expire on the following: (Fill in the Date or the Event, but not both.) Date: 04/20/14 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be requested or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input checked="" type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92; <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. ggz (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it. 7. A photostatic copy of this Authorization is to be considered as effective as the original.					
Section B:					
THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Joyce J. Lovelace				Date: 03/21/2013	
Print Name of Patient/Plan Member's Representative: Joyce J. Lovelace				Relationship to Patient/Plan Member: Wife	

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Mary Neal Martin Patient Identifier: DOB: 1923

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider: Saint Thomas Outpatient Neurosurgical Center, LLC; Howell Allen Clinic A Professional Corporation; St. Thomas Hospital; John Weeks Culclasure, M.D.; Debra V. Schamberg, R.N.

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

Howell Allen Clinic A Professional Corporation or any representative, attorney or investigator from said organization, c/o Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste 301, Nashville, TN 37203-2023.

Purpose of the Requested Use or Disclosure

At the request of the undersigned

Expiration and Revocation of This Authorization

Expiration Date or Event: 10/30/2013

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

Signature (Patient)

Date

Signature (Authorized Representative) Date

Signature (Witness)

Relationship to Patient

Patricia Martin 4/30/2013
Daughter

Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: <i>Joyce P. McKirney</i>		Birth Date: <i>- 1939</i>		Social Security No. <i>1- 6954</i>	
Provider's/Health Plan's Name & Address: <i>See Attached</i>		Recipient's Name: <i>Dr. John W. Culclasure</i>			
		Address 1: <i>Saint Thomas Outpatient Neurosurgical Center</i>			
		Address 2: <i>4230 Harding Road, Ste. 901</i>			
		City: <i>Nashville, TN 37205</i>			
		State:		Zip:	
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: _____ Event: <i>Conclusion of Litigation</i>					
Purpose of disclosure: <i>COMPLIANCE WITH T.C.A. § 29-26-121</i>					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input checked="" type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input checked="" type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it.					
Section B:					
The purpose of the release of my records is for review by the above named recipient for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by <i>the above named recipient</i> shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel William D. Vines, III, Butler, Vines & Babb, PLLC, 2701 Kingston Pike, Knoxville, TN 37919, within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated:					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Joyce P. McKirney</i>				Date: <i>6-12-13</i>	
Print Name of Patient/Plan Member's Representative:				Relationship to Patient/Plan Member:	

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: <i>Melanie Miller</i>		Birth Date: <i>1/77</i>		Social Security No. (optional): <i>-2284</i>	
Provider's/Health Plan's Name:		Recipient's Name:			
Provider's/Health Plan's Address:		Address 1:			
		Address 2:			
		City:	State:	Zip:	
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: <i>April 1, 2014</i> Event:					
Purpose of disclosure: <i>COMPLIANCE WITH T.C.A. § 29-26-121</i>					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input checked="" type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. <i>[Signature]</i> (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it.					
Section B:					
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Melanie Miller</i>				Date: <i>5/28/13</i>	
Print Name of Patient/Plan Member's Representative: <i>Robert Young</i>				Relationship to Patient/Plan Member: <i>Attorney</i>	

Revised 3/2003

Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: <i>Dorothy Nassif</i>		Birth Date: <i>3/45</i>		Social Security No. (optional): <i>1-9080</i>	
Provider's/Health Plan's Name:		Recipient's Name:			
Provider's/Health Plan's Address:		Address 1:			
		Address 2:			
		City:	State:	Zip:	
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: <i>April 1, 2014</i> Event:					
Purpose of disclosure: <i>COMPLIANCE WITH T.C.A. § 29-26-121</i>					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input checked="" type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery room <input type="checkbox"/> OB nursing notes <input type="checkbox"/> Post-partum flow sheet <input type="checkbox"/> Itemized bill <input type="checkbox"/> UB-92 <input type="checkbox"/> Other all diagnostic films, x-rays, MRI, CAT scans, etc. <input type="checkbox"/> Other	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. <i>DN</i> (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any action taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it.					
Section B:					
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by the office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office. A Bates-numbered copy shall be furnished to my counsel (attorney and address), within five (5) days after the records are obtained through the [this authorization].					
Section C: Signature					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Dorothy Nassif</i>				Date: <i>5/20/13</i>	
Print Name of Patient/Plan Member's Representative: <i>Robert Yorum</i>				Relationship to Patient/Plan Member: <i>Attorney</i>	

Revised 3/2003

C-4

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <u>Ken Pierce</u>	Birth Date: <u>1/10</u>	Serial Security No. (optional): <u>1-3398</u>
Provider's/Health Plan's Name:	Recipient's Name:	
Provider's/Health Plan's Address:	Address 1:	
	Address 2:	
	City:	State: Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. K (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>[Signature]</u>	Date: <u>5/23/13</u>
Print Name of Patient/Plan Member's Representative: <u>Larry E. (Ken) Pierce Jr. Robert Wang</u>	Relationship to Patient/Plan Member: <u>Attorney</u>

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations.

Patient/Plan Member Name: Elizabeth A. Proffitt Birth Date: 1/13/59 Social Security No.: -5519

Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital
Saint Thomas Network
Saint Thomas Health
Saint Thomas Medical Clinic

Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 04/20/14 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. ICS (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard: KINNARD, CLAYTON & BEVERIDGE, 127 Woodmont Boulevard, Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Lose C. Shadowhawk

3-21-13

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Lose C. Shadowhawk

Daughter

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: J.W. Ragland	Birth Date: 7/41	Social Security No.: .8512
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 04/20/14 **Event:**

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. BR (Initial) If not applicable, check here. ☐

I understand that:


1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: 	Date: 3-27-2013
Print Name of Patient/Plan Member's Representative: Becky Ragland	Relationship to Patient/Plan Member: Wife

Section A: This section must be completed for all Authorizations.					
Patient/Plan Member Name: Thomas W. Rybinski		Birth Date: 7/56		Social Security No.: 8468	
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic		Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC			
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: 04/20/14 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess. <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. <u>SCR</u> (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it. 7. A photostatic copy of this Authorization is to be considered as effective as the original.					
THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Silva Colette Rybinski</i>				Date: 3/20/13	
Print Name of Patient/Plan Member's Representative: Colette Rybinski				Relationship to Patient/Plan Member: Wife	

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
PURSUANT TO HIPAA C.F.R. 164.512

I authorize the use/disclosure of health information as described below.

1. Person(s) or class of persons, medical provider or other entity or person authorized to disclose the information: _____
2. Person(s) or class of persons or provider, company or entity to whom the information may be disclosed: ST. THOMAS OUTPATIENT NEUROSURGICAL CENTER, LLC
3. I understand that this may include information relating to acquired immunodeficiency syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus), psychiatric care, treatment for alcohol and/or drug abuse, and/or genetic testing.
4. Description of information to be disclosed: Medical records and reports, patient information and history forms, x-rays, x-ray report, pathology, pathology reports, insurance records, health care providers' reports and consultations, prescriptions, off-work slips, therapy records, lab reports, notes, tests and billing records and statements.
5. The information will be used/disclosed for the following purposes: For medical providers and any other person or entity to obtain medical records for the purpose of determining what happened to John Charles Sawyers and what persons, manufacturers, distributors, purchasers or entities are responsible for causing injury to Mr. Sawyers and for any other lawful purpose.
6. I understand that the health information described above may be redisclosed and no longer protected by federal and state privacy regulations.
7. I understand that my healthcare or payment for healthcare will not be affected if I refuse to sign this authorization.
8. In consideration of the release of information by _____, in accordance with this request, I hereby release _____, its agents, servants, and employees from any and all claims, demands, or liability of any kind, which might arise or from the release of such information and the effects thereof.

I understand that I have the right to revoke this authorization in writing at any time by sending written notice of revocation to the person(s), class of persons or provider, company or entity at the above address. I understand my revocation of this authorization will not be effective as to uses and/or disclosures of any information that the person(s) and/or organization have previously provided. A copy of this signed release shall be deemed as effective as if it were the original.

This authorization shall expire two years from the date of its execution.

John Charles Sawyers
JOHN CHARLES SAWYERS

DOB: 1949
S.S. NO: H-3457

John Charles Sawyers

DATE: 6-10-13

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <i>McLaine Stinson</i>	Birth Date: <i>1/6/60</i>	Social Security No. (optional): <i>-1882</i>	
Provider's/Health Plan's Name:	Recipient's Name:		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: *April 1, 2014*

Event:

Purpose of disclosure: *COMPLIANCE WITH T.C.A. § 29-26-121*

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *MS* (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>McLaine Stinson</i>	Date: <i>5/17/13</i>
Print Name of Patient/Plan Member's Representative: <i>Robert Young</i>	Relationship to Patient/Plan Member: <i>Attorney</i>

Revised 3/2003

AUTHORIZATION TO DISCLOSE HEALTH INFORMATIONPatient Name Barbara A. TaylorDate of Birth 1949 Social Security Number 148

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure: all medical sources, healthcare providers and treaters.

Address: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

<input type="checkbox"/> physician/nurse assessment	<input type="checkbox"/> medication list	<input type="checkbox"/> history and physical
<input type="checkbox"/> discharge summary	<input type="checkbox"/> laboratory results	<input type="checkbox"/> x-ray and imaging\ reports
<input type="checkbox"/> consultation reports	<input checked="" type="checkbox"/> entire record	<input type="checkbox"/> patient information sheet
<input type="checkbox"/> other: _____		
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization: all medical sources, healthcare providers and treaters, and their representatives,

for the purpose of litigation and to comply with Tenn. Code Ann. § 29-26-121.
6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department and requesting party. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I fail to specify an expiration date, event or condition, this authorization will expire in one (1) year. I further authorize the above referenced provider to accept a copy of this Authorization instead of the original of this document, said copy to have full force and effect as though it were the original.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Barbara A. Taylor
Signature of Patient or Legal Representative

6-20-13
Date

If Signed by Legal Representative, Relationship to Patient

Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: Blake Taylor		Birth Date: 82		Social Security No. (optional): 0293	
Provider's/Health Plan's Name:		Recipient's Name:			
Provider's/Health Plan's Address:		Address 1:			
		Address 2:			
		City:		State:	Zip:
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: April 1, 2014 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input checked="" type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. BT (initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it.					
Section B:					
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Blake Taylor				Date: 5/23/13	
Print Name of Patient/Plan Member's Representative: Robert Young				Relationship to Patient/Plan Member: Attorney	

Revised 3/2003

STATE OF TEXAS AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <i>Bondel Turner</i>	Birth Date: <i>1/6/03</i>	Signature (optional): <i>1-1107</i>	
Provider's/Health Plan's Name:	Recipient's Name:		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following (Fill in the Date or the Event but not both.)

Date: *April 1, 2014*

Event:

Purpose of disclosure: *COMPLIANCE WITH T.C.A. § 29-26-121*

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record		<input checked="" type="checkbox"/> Operative Information		<input checked="" type="checkbox"/> Labor/delivery sum.	
<input checked="" type="checkbox"/> Admission form		<input checked="" type="checkbox"/> Cath lab		<input checked="" type="checkbox"/> OB nursing assess	
<input checked="" type="checkbox"/> Dictation reports		<input checked="" type="checkbox"/> Special test/therapy		<input checked="" type="checkbox"/> Postpartum flow sheet	
<input checked="" type="checkbox"/> Physician orders		<input checked="" type="checkbox"/> Rhythm Strips		<input checked="" type="checkbox"/> Itemized bill:	
<input checked="" type="checkbox"/> Intake/outtake		<input checked="" type="checkbox"/> Nursing Information		<input checked="" type="checkbox"/> US-92:	
<input checked="" type="checkbox"/> Clinical Test		<input checked="" type="checkbox"/> Transfer forms		<input checked="" type="checkbox"/> Other: all diagnostic	
<input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> ER Information		films, x-rays, MRIs,	
				CAT scans, etc.	
				<input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *[Signature]* (initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I/my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Revised 3/2003

Patient/Plan Member Name: <i>Kristy Wilkinson</i>	Birth Date: <i>1/70</i>	Social Security No. (optional): <i>2313</i>	
Provider's/Health Plan's Name:	Recipient's Name:		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: *April 1, 2014* Event:

Purpose of disclosure: *COMPLIANCE WITH T.C.A. § 29-26-121*

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *WW* (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Kristy Wilkinson</i>	Date: <i>5/23/13</i>
Print Name of Patient/Plan Member's Representative: <i>Robert Young</i>	Relationship to Patient/Plan Member: <i>Attorney</i>

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Earline T. Williams Patient Identifier: DOB: 1940

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider: Saint Thomas Outpatient Neurosurgical Center, LLC; Howell Allen Clinic A Professional Corporation; St. Thomas Hospital; John Weeks Culclasure, M.D.; Debra V. Schamberg, R.N.

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

Saint Thomas Outpatient Neurosurgical Center, LLC or any representative, attorney or investigator from said organization, c/o Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste 301, Nashville, TN 37203-2023 or Floor 9, 4230 Harding Pike, Nashville, TN 37205-2013.

Purpose of the Requested Use or Disclosure

Legal

Expiration and Revocation of This Authorization

Expiration Date or Event: 10/11/13

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

Signature (Patient)

Date

Mother Williams 4/11/13
Signature (Authorized Representative) Date

SON

Signature (Witness)

Relationship to Patient